CLEARINGHOUSE

MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

MEDICAID FRAUD AND ABUSE CONTROL

SURVEY DATA BOOK

June 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

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Survey Data

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Medicaid Fraud and Abuse Control

Survey Data Book

Prepared Under SRS Contract No. SRS-500-75-0004

by

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Medicaid Bureau

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I. INTRODUCTION

This report presents the data resulting from the Medicaid Fraud and Abuse Control Mail Survey conducted by the General Research Corporation (GRC) as part of its work under contract SRS 500-75-0004 with the Social and Rehabilitation Service of the U.S. Department of Health, Education, and Welfare. The survey was designed to gather information concerning Medicaid fraud and fraud control methods used by the states and the District of Columbia. A similar survey was also conducted concerning fraud in the AFDC program.* Exhibit 1 presents a list of all states and notes their cooperation or noncooperation in both the Medicaid and AFDC surveys. A detailed list of respondents and notes concerning their responses appear in Appendix A. Thirty nine of the 50** jurisdictions provided codable responses to all of part of the Medicaid survey. The survey instrument is reproduced in Section II of this report along with a tabulation of responses for each question and response category. The paragraphs below present a discussion of the background of the mail survey and the methodology used to conduct the survey.

As the project evolved, the development and use of mail survey instruments became a major project effort. Although the contract specified in general terms many of the items to be covered in the surveys, considerable research went into refining these items into specific questions suitable for response by mail. Before questions could be developed, the project staff had to become quite familiar with the Medicaid and AFDC environments. This was accomplished not only through the examination of DHEW and state documents but also through the conduct of the pre-test site visits. States visited in this phase included New York, Virginia, North Carolina, and Illinois. A complete Medicaid fraud and abuse literature review was also prepared.

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*The reader interested in the AFDC survey is referred to the GRC publication "AFDC Fraud Control Mail Survey Data Book," June 1977.

**Arizona has no operating Medicaid program.

Exhibit 1

MAIL SURVEY PARTICIPATION

State	AFDC		Medicaid	
	Codable Response	No Codable Response	Codable Response	No Codable Response
Alabama	X		X	
Alaska	X			X
Arizona*	X		---	
Arkansas	X		X	
California	X		X	
Colorado		X		X
Connecticut	X		X	
Delaware	X		X	
D.C		X	X	
Florida	X		X	
Georgia	X		X	
Hawaii	X			X
Idaho	X		X	
Illinois		X		X
Indiana		X		X
Iowa	X		X	
Kansas	X			X
Kentucky	X		X	
Louisiana		X		X
Maine	X		X	
Maryland	X			X
Massachusetts	X		X	
Michigan	X		X	
Minnesota		X		X
Mississippi	X		X	
Missouri		X	X	
Montana	X		X	
Nebraska	X		X	
Nevada	X		X	
New Hampshire	X		X	
New Jersey	X		X	
New Mexico	X		X	
New York	X			X
North Carolina	X		X	
North Dakota	X		X	
Ohio	X		X	
Oklahoma	X		X	
Oregon	X		X	
Pennsylvania	X		X	
Rhode Island	X		X	
South Carolina	X		X	
South Dakota		X		X
Tennessee	X		X	
Texas	X		X	
Utah	X		X	
Vermont	X		X	
Virginia	X		X	
Washington	X		X	
West Virginia	X		X	
Wisconsin		X	X	
Wyoming	X		X	
Total	42	9	39	11

*No Medicaid program.

GRC program staff members designed survey instruments based on all this background information. The instruments were then refined and modified to meet SRS needs which developed after the initial design of the instruments. The instruments were submitted to OMB for approval, accompanied by a clearance package largely prepared by GRC. After considerable delay, OMB cleared the instruments although certain changes were requested (and made) which GRC believes weakened the instruments. For example, certain questions are designed to determine the prevalence of particular types of Medicaid fraud or abuse in a given state. The question asked what proportion of fraud or abuse fell into each of a large number of categories. The final approved response categories were "don't know," "0-25%," "26-50%," "51-75%," and "76-100%." We argued, unsuccessfully, that the low end categories should encompass must smaller ranges than the high end categories since most states were likely to report only small frequencies in each category. As the question stands, a state with no problem with a particular type of abuse cannot be distinguished from a state with perhaps 25 percent of its abuse in that category. In other instances, OMB-required changes appear to give responses greater precision than we believe is justified by information available to state personnel completing the forms. We originally proposed responses such as "never or rarely," "occasionally," and "frequently" for certain questions. Although these terms may be interpreted differently by different respondents, we believed that the underlying poor quality of state fraud data would not allow respondents to answer with any more than impressionistic accuracy. Unfortunately, those who now see state responses in percentage terms may mistakenly believe that the reported percentages are firm numbers of great accuracy. In virtually all cases, they are not -- if our experience in the visited states, which were selected because of their "good" programs, is typical.

The questionnaire is divided into topical sections with appropriate skip patterns. Sections in the Medicaid questionnaire are:

I. Medicaid Provider
   - Detection Methods
   - Investigative Methods
   - Administrative Actions
   - Needs and Plans

II. Medicaid Recipients

III. Medicaid Agency (Employee)

Procedures for use of the mail survey instruments were developed in parallel to the development of the instruments themselves. A basic decision was made early in the procedures development process that steps should be taken to the extent possible to minimize the burden on any one recipient. This was obviously a difficult problem since the Medicaid questionnaire is 48 pages long. The burden is minimized, of course, if one individual is not asked to respond to more than a few pages or a section of the questionnaire. To make this possible, we asked the assistance of the DHEW Regional Offices in the identification of those individuals in state programs responsible for various aspects of Medicaid administration. To the extent that the Regional Offices supplied this information, our plan was to send the questionnaires to all appropriate individuals with instructions for them to respond only to the questions which are their direct responsibility. Before mailing the questionnaires to these individuals, of course, we notified the state directors of our plans and asked them to advise us if they preferred an alternate approach. In general, most state directors endorsed our plan. For states concerning which we had no information about the most appropriate respondents, we sent the questionnaires directly to the state directors and asked them to respond or divide the responsibility among the appropriate members of their staff.

Questionnaires were mailed to respondents in packets which contained the following items:

- Personal letter to state director (or copy of that letter if the respondent was not the state director)
- SRS Action Transmittal explaining the questionnaire and requesting cooperation
- Instruction sheet
- Medicaid questionnaire
- Addressed return envelope

The letter and Action Transmittal both included paragraphs inviting respondents to call or write the project officer or the GRC project manager if they needed any additional information or assistance in completing the forms. All forms were also stamped with a due date of

approximately six weeks after their mailing. The survey packets were sent out in two waves several weeks apart to lessen the concentrated preparation burden on the project staff and especially to ensure that all (labor intensive) follow-up activities did not have to begin on the same day. The material included in the packet is reproduced in Appendix B.

The packets also contained a brief Unit Budget and Staffing Characteristics Questionnaire, which is also included in Appendix B. A major problem developed concerning tabulation of these questionnaires. The problem resulted in the decision not to tabulate them. Some states reported information specifically for unit charged with fraud and abuse control. Others reported data for much larger divisions or departments which have wide-ranging responsibilities. It was impossible to separate out fraud and abuse control as a separate area for these responses, so these responses could not be analyzed with the specific fraud control units. Follow-up activities confirmed that states which supplied information at the division or department level were unable to supply information at the specific unit level. Thus, comparisons between the states were impossible. The information supplied by the states is contained in the State Response Files delivered to the DHEW project officer.

As expected, a large proportion of the states did not return the questionnaires by the due date despite the fact that six weeks had been allowed. Follow-up activities were initiated for these states. All states not responing received a second Action Transmittal which included an individually prepared note stating that all or part (as appropriate) of their state's replies had not been received. Telephone calls were also made in appropriate cases. States which did reply also received an SRS Memorandum thanking them for participating. All Action Transmittals and Memoranda used were prepared by GRC and approved by the project officer and other SRS officials. SRS Field Operations staff advised during this process.

Once survey instruments were returned by the states to GRC, the instruments were logged into our survey control file. They were then scanned for completeness. Instances of multiple respondents answering the same question for a given state were examined and resolved. A package containing as complete a set of replies as possible for each state was then compiled for use by data coding specialists.

The decision was made early in the design of the survey not to plan for computer tabulation of the responses. This decision was based on the expected quality of the data and the expected likelihood of written explanation being made for answers to particular questions. Since keypunchers would be unable to deal with these problems and explanations and since the number of responses was small enough to make manual processing possible, turning the packages over to tabulation personnel given training to make them capable of identifying major problems in responses for resolution by the project manager or capable of resolving minor problems themselves was chosen as the best course of action. Thus tabulation became more than just a mechanical process. Tabulations are presented in the next section.

II. TABULATIONS

This section presents tabulations from the Medicaid mail survey. A survey form is reproduced on the following pages. The number of states making each response to each question is indicated.

Several cautions in relation to interpretation of this data are in order. Indeed, the necessity for these cautions also led GRC to not conduct a detailed analysis of the data rather than simply presenting the returns as they were supplied by the states. We believe conclusions based on detailed analysis would be unreliable.

- The state supplied data is likely to be unreliable in many instances. Medicaid program personnel within DHEW have warned the project staff that data supplied to DHEW by the states is variable in its quality; often the answer supplied to a given question depends on to whom the question is addressed within a state. We have no reason to believe responses to this survey are higher in quality. Thus responses to this questionnaire must be regarded with a certain degree of suspicion. In various states for various questions, responses may be based on records, educated guesses, or simply on conjecture. And as noted, states often simply ignored individual questions.

- We report the number of states which responded with each possible answer. Thirty-nine states* responded to all or part of the Medicaid questionnaire. However, many states did not respond to particular questions within the questionnaire.

This document presents only the number of states that made each response to each question. The reader interested in the response of any particular state to the survey is referred to the questionnaire tabulation work sheets supplied to the government by GRC. These documents list each possible response to each question and specify the states which made each response. The returned questionnaires and accompanying documents supplied by the states were also supplied to the project officer.

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*Including the District of Columbia.

GENERAL RESEARCH CORPORATION

OMB Number 83-S-75011
Expires: 5-77

MEDICAID FRAUD AND ABUSE CONTROL SURVEY

This survey is designed to obtain baseline data on state activities which relate to fraud control in the Medicaid program. Based upon previous contacts with the head of your agency, you have been identified as having responsibilities relating to fraud control. Other persons in your state who also have fraud control responsibilities may also be receiving this survey. It will, therefore, be necessary for you to respond only to those questions which directly relate to your areas of responsibility. To aid you in determining which questions you may need to answer, the survey is organized into three major sections -- Medicaid Provider, Medicaid Recipients, and Medicaid Agency. Within each section, there are subsections which define specific fraud related responsibilities. Each subsection begins with a description of the questions in that section and asks you to check whether or not you have responsibilities in that area. If you do not, instructions appear which will tell you the question number you may skip to. This question number will begin a set of questions with regard to another area of responsibility.

Please complete all subsections of this survey for which your unit has responsibilities, and the information section below.

To assist you in responding to these questions and to ensure the collection of uniform data, definitions of terms frequently used in this instrument are provided below.

Number of cases involving questions of fraud or abuse. This term refers to the number of cases produced by initial detection methods in which a possibility of provider fraud/abuse may exist, regardless of whether or not the case developed into a full-scale investigation.

Number of cases involving suspected fraud or abuse. This term refers to the number of cases in which an investigation has indicated that there is a reasonable indication that fraud or abuse has occurred.

Cases of fraud/abuse. While cases of fraud are typically defined in terms of court decisions, for the purposes of this study fraud/abuse cases are any cases which have resulted in legal or administrative determination of fraud/abuse. This would include all cases of fraud/abuse where providers have been terminated or suspended, issued warning letters to cease certain practices, required to make restitution and/or referred for prosecution.

Thank you for your cooperation.

Please return this questionnaire by MAR 2 2 1977

to: General Research Corporation
7655 Old Springhouse Road
McLean, Virginia 22101

State:_____

Organizational Unit	Respondent
Name:_____	Name:_____
Address:_____	Position:_____
_____	Telephone: ( )_____
_____	

Date on which your unit began having responsibilities for Medicaid fraud and abuse control: [Month] [Year]

MEDICAID PROVIDER
SECTION I

DETECTION METHODS

1. The questions in this section are designed to obtain information on the use of various detection methods, including computer operations used to uncover fraud and abuse. The use of a computer generated profiles, verification of services, and other methods for uncovering cases of suspected fraud are essential for understanding your efforts to control fraud and abuse. Do you or members of your staff have responsibilities for fraud and abuse detection?

☐ yes (Proceed to Question 2)

☐ no (Skip to Question 17)

2. The table below lists several methods which you may use to detect cases of fraud/abuse. Based upon the total number of cases involving a question of fraud/abuse in FY76, please indicate below the percentage of cases which were detected from each source.

Detection Method	FREQUENCY			
	0-25%	26-50%	51-75%	76-100%
Recipient Verification of Services	28	2	1	1
Review and Edit of Claims	20	4	7	1
Review of Provider Profiles	22	8	2	1
Review of Patient Profiles	24	7	1	1
Third Party Complaints	17	5	0	1
Medicare Referrals	28	2	0	0
Routine Audits	24	5	1	1
Other (specify) Recipient Complaints	2	1	1	0
Internal Referrals	5	1	0	1

3. To what extent have the following methods for stimulating third party complaints been used?

Method	EXTENT OF USE		
	Never Used	Occasionally Used	Frequently Used
Public Information Campaign	18	12	1
Recipient Education Effort	17	19	5
Promotion of Concern Among Provider Groups	3	19	9
Promotion of Concern Among Health Insurance Carriers	9	19	3
Other (specify) Welfare Agencies	1	0	1

4. The table below lists various detection techniques which may be used to uncover abuse/fraud among various providers. For each provider listed, check as many methods as you employ for detecting abuse or fraud by that provider category. Please add to the table any other detection methods you employ and check the provider groups to which each is applicable.

Method of Detection	Provider Type											
	Physicians	Dentists	Other Health Professionals	Hospitals	Nursing Homes	Laboratories	Pharmacies	Home Health Agencies	Other Institutional Providers	Other (Specify) Transportation	Other (Specify) Medical Supplies	Other (Specify) All Other
Recipient Verification of Services	28	27	26	23	19	24	26	29	14	3	3	4
Review of Claims Records	32	31	29	29	27	27	30	26	20	3	4	4
Review of Provider Profiles	32	29	26	22	21	23	28	20	13	5	4	4
Review of Patient Profiles	31	26	25	23	23	25	29	17	17	4	3	3
Third Party Complaints	31	31	28	28	27	26	26	18	18	2	3	3
Medicare Referrals	22	12	18	22	19	17	10	14	8	2	3	1
Routine Audits	22	22	20	22	27	17	24	13	10	1	1	1
Other (Specify): Recipient Complaints	3	3	3	3	2	3	3	2	2	0	0	0
Internal Referrals	2	2	2	1	2	2	2	1	1	0	1	0
Spot Check and Special Audits	0	0	0	0	0	0	3	0	0	0	0	0
Peer Review of Dental Work	0	2	0	0	0	0	0	0	0	0	0	0

5. Do you have a hot line to receive complaints?

[8] Yes [26] No

6. Do you have a system for routine verification of services with recipients?

[25] Yes [9] No (Skip to Question 10)

7. About what percentage of the complaints received last year (FY 76) resulted from verification of services?

* Percent of complaints

*This data cannot be meaningfully averaged. See data tabulation sheets for individual state responses.

8. How frequently are verification of services performed?

[18] At least monthly

[4] At least quarterly but less often than monthly

[0] At least semi-annually but less often than quarterly

[1] At least annually but less often than semi-annually

[2] Less often than annually

9. What percent of recipients are sampled each time?

[15] Less than 10%

[1] 11% to 25%

[0] 26% to 50%

[0] 51% to 75%

[9] 76% to 100%

10. Do you use a computer as a tool in your abuse and fraud detection or investigation activities?

[29] Yes [5] No (Skip the remaining questions in this section.)

11. Does the computer routinely provide you with reports related to your Medicaid provider fraud and abuse control activities?

[21] Yes [9] No (Skip to Question 15)

12. Please indicate in the table below the types of reports that are routinely generated for your abuse and fraud detection/investigation activities, and how often they are generated. Please attach sample copies to this questionnaire.

Report Type	How Often Generated	Copy Attached	Copy Not Attached (Explain)
*		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____

*See state response files.

13. Are these routine reports generated prior to or only after claims have been processed and paid?

[1] Before Payment (Prospective Reports)

[24] After Processing and Payment (Retrospective Reports)

14. Do routine reports include information on providers who engage in practices that are outside of pre-established norms?

[17] Yes [5] No (Skip to Question 16)

15. Please indicate in the table below: (1) all dimensions or factors (e.g., total dollar volume per month) on which providers' claims histories are routinely checked for exceptional patterns, and (2) the values (or criteria) above or below which a provider is considered exceptional for each dimension. [If a list of exception criteria is available, please attach.]

Provider Type	Dimension Reviewed	Minimum Acceptable Value	Maximum Acceptable Value
	See state response files.		

16. What other reports, not generated routinely, are available upon request by your unit and how long does it take to obtain each type of report desired? Please attach sample copies.

Report Type	Turn Around Time	Copy Attached	Copy Not Attached (Explain)
*		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____

*See state response files.

INVESTIGATIVE METHODS

17. The questions in this section are designed to obtain basic data on the types of Medicaid Provider fraud and abuse commonly found in your state, investigative powers of your unit, and number and types of investigations undertaken by your unit.

The first three questions separate kinds of fraud by practitioners, institutions, and other providers.

Do you or does someone in your unit have responsibilities for investigation of provider fraud and abuse?

☐ yes (Proceed to Question 18)

☐ no (Skip to Question 24)

18. The table below lists several types of fraud and abuse practitioners reportedly have used to increase the money received from the Medicaid program. Based upon the total number of cases of fraud/abuse in FY76, please complete the table below indicating (1) the percentage of cases which each type of fraud or abuse accounted for, and (2) whether, when it does occur, it typically involves less than $1,000, $1,000 to $4,999, $5,000 to $9,999 or $10,000 or more for each provider case of that kind of fraud.

Type of fraud or abuse	Don't know	Frequency				Dollars Involved			
		0-25%	26-50%	51-75%	76-100%	Less than $1,000	$1,000 to $4,999	$5,000 to $9,999	$10,000 or more
Charges for services not delivered	6	16	6	3	2	8	4	3	8
Kickbacks and related schemes	19	13	0	1	0	8	0	2	2
Billing the state more than once for the same service	9	19	4	0	0	17	0	0	5
Billing both the state and the recipient or health insurance carrier for the same service	10	20	3	0	0	17	1	2	2
Billing the recipient for the difference between the Medicaid rate and their usual fee	10	18	3	1	0	15	1	2	2
Overutilization	10	13	1	6	2	10	3	0	7
"Gang" visits to nursing homes or hospitals 1/	15	15	2	0	0	11	0	0	3
Special Medicaid rates 2/	16	14	2	0	0	10	1	7	1
Billing for more expensive services than actually provided	10	16	3	3	0	11	3	1	4
"Ping-ponging" of patients 3/	17	11	1	3	0	6	0	1	4
Other (specify) _____	12	14	2	1	3	7	1	1	8

1/ "Gang visits" to hospitals or nursing homes refers to a single visit by a physician to an institutional facility during which he sees a large number of patients for a very short amount of time per patient and then bills Medicaid for a separate visit for each.

2/ Special Medicaid rates refers to charging Medicaid a higher price for a service than would be charged to private patient.

3/ "Ping-ponging" refers to unnecessary referrals of patients between specialists for the purpose of increasing the billings of each doctor. While there is sometimes a kick-back arrangement between physicians involved in such referrals, any unnecessary referrals among a group of physicians constitutes ping-ponging.

19. The table below lists several types of fraud and abuse institutional providers have reportedly used to increase the money received from the Medicaid program. Based on the total number of cases of fraud/abuse in FY76, complete the table below, indicating (1) the percentage of cases which each type of fraud or abuse accounted for, and (2) whether, when it does occur, it typically involves less than $1,000, $1,000 to $4,999, $5,000 to $9,999 or $10,000 or more for each provider case of that kind of fraud.

Type of fraud or abuse	Don't know	Frequency				Dollars Involved			
		0-25%	26-50%	51-75%	76-100%	Less than $1,000	$1,000 to $4,999	$5,000 to $9,999	$10,000 or more
Charges for unnecessary items and services unrelated to patient care	12	14	2	1	3	7	1	1	8
Charges for services not rendered	11	17	2	1	0	8	4	1	4
Charges for nonexistent or deceased patients	14	17	0	0	0	9	3	1	1
Absenteeism or phantom staff	20	8	2	0	0	5	1	2	2
Conflict of interest	23	7	0	0	0	5	0	1	0
Financial manipulation	18	9	2	0	1	5	0	1	5
Manipulation of ownership	20	9	0	1	0	4	1	1	2
Use of unlicensed staff	19	11	0	0	0	5	1	1	0
Bribery	23	5	1	0	0	5	1	0	0
Other (specify) _____	8	14	5	2	0	8	3	2	4

20. The table lists several types of fraud and abuse laboratories, pharmacies and other medical vendors have reportedly used to increase the money received from the Medicaid program. Based upon the total number of cases of fraud/abuse in FY76, please complete the table below indicating (1) the percentage of cases which each type of fraud or abuse accounted for, and (2) whether, when it does occur, it typically involves less than $1,000, $1,000 to $4,999, $5,000 to $9,999, or $10,000 or more for each provide case of that kind of fraud.

Type of fraud or abuse	Don't know	Frequency				Dollars Involved			
		0-25%	26-50%	51-75%	76-100%	Less than $1,000	$1,000 to $4,999	$5,000 to $9,999	$10,000 or more
Charging brand name prices for generic drugs	8	16	5	1	1	9	2	1	5
Prescription splitting 1/	20	7	0	0	0	4	0	0	2
Illegal quantity discounts	17	11	0	1	0	7	1	0	1
Selling unauthorized drugs	11	16	1	1	0	10	1	0	3
"Shorting" prescriptions 2/	15	13	0	1	0	8	2	1	2
"Kiting" prescriptions 3/	13	12	2	2	0	5	1	0	4
Billing automated multiple tests as individual tests	19	8	2	0	0	4	1	0	4
Kickbacks and silent partnerships with physicians	11	14	3	1	0	4	1	1	6
Charges for services not rendered	15	8	1	2	1	5	4	0	1
Special Medicaid rates	7	2	1	0	1	1	2	0	1
Other (specify) _____	0	0	0	0	0	0	0	0	0

1/ Prescription splitting refers to the practice of filling a prescription in smaller than the prescribed amounts, thereby requiring frequent refills. Each time the prescription is refilled an administrative cost is added to the bill submitted to Medicaid.

2/ "Shorting" a prescription refers to measuring out a quantity of medication less than that originally prescribed by the practitioner. The pharmacist then charges Medicaid for the prescribed amount and pockets the difference.

3/ "Kiting" a prescription refers to the pharmacist's tampering with the dosage written on the prescription by adding "xxs" to increase the amount. The prescription is filled for the original amount but Medicaid is billed for the increased amount now shown on the prescription.

21. In the table below, please indicate (1) whether or not your unit has the authority to perform the following functions, and (2) whether the authority or lack of authority has had a positive effect, no effect, or a negative effect on your unit's ability to perform its investigative functions.

Function	Authority		Effect on Investigative Ability		
	Yes	No	Positive	No effect	Negative
Serve a search warrant	4	20	6	22	5
Serve a subpoena	10	13	10	18	4
Confiscate evidence	14	17	13	11	6
Review law enforcement records	20	12	18	11	3
Review financial records of providers	25	9	25	3	5
Review patient records	31	3	30	2	1
Make arrests	3	29	4	21	6
Have peace officer status	4	29	3	21	6
Other (specify) _____					
Obtain notarized statement	0	1	0	1	0
Review records of non-Medicaid patients	0	1	0	1	0

22. In the table below please indicate (1) the number of each specific type of provider participating in Medicaid in FY76, (2) the number of investigations completed for each specific provider type in FY76, and (3) the percent of total investigative staff time applied to each general provider category in FY76.

General provider category	Specific provider type	Number of participants	Number of investigations	Percent of total investigative staff time involved
Practitioners	Physicians	*	*	41 % **
	Dentists	*	*	
	Home health services	*	*	
	Other practitioners (specify)	*	*	
Acute care institutions	Clinics	*	*	7 % **
	Out-patient hospitals	*	*	
	In-patient hospitals	*	*	
Long-term care institutions	Intermediate care facilities	*	*	15 % **
	Skilled nursing facilities	*	*	
Medical vendors	Ambulance services	*	*	17 % **
	Pharmacies	*	*	
	Laboratories	*	*	
	Medical equipment supplies	*	*	

*This data cannot be meaningfully averaged. See data tabulation sheets for individual state responses.

**These averages are based on responses from 17 states. The responses of some states did not total 100%. Thus the total shown here does not total 100%. The data should be considered only suggestive.

23. Please complete the form below, indicating the status of fraud and abuse investigations by your unit in the fiscal years indicated.

	FY 76		FY 77	
Part I. Allegations and Results of In-house Documentation Review	Cases	Don't Know	Cases	Don't Know
A. Allegations awaiting in-house documentation review beginning of fiscal year	*	10	*	8
B. New allegations received or developed during fiscal year	*	5	*	4
C. Completed in-house documentation reviews	*	6	*	5
C.1 Allegations dropped	*	5	*	5
C.2 Cases referred for administrative actions	*	6	*	7
C.3 Allegations with evidence sufficient to merit field investigations	*	6	*	6
Part II. Field Investigations and Agency Enforcement Actions				
A. Field investigations in process at beginning of fiscal year	*	6	*	4
B. Field investigations begun during fiscal year	*	8	*	5
C. Cases referred to law enforcement officials	*	5	*	4
D. Field investigations closed by administrative action	*	6	*	5
E. Field investigations dropped for lack of evidence	*	8	*	6
Part III. Law Enforcement Actions and Prosecutions				
A. Cases awaiting law enforcement actions or in prosecution at beginning of fiscal year	*	6	*	4
B. Law enforcement actions completed and cases closed	*	5	*	4
Part IV. Amounts Recovered During Fiscal Year	Dollars			
A. Amount identified as improperly obtained	*	7	*	2
B. Amounts recovered from prosecution	*	7	*	5
C. Total amount recovered from all sources, including prosecutions	*	6	*	5

*These data cannot be meaningfully averaged. See data tabulation sheets for individual state responses.

ADMINISTRATIVE ACTIONS

24. The questions in this section are designed to obtain information on the kinds of administrative actions (e.g., suspension, termination, obtaining restitution, and referring cases to law enforcement officials) which your unit can and has taken. Do you have responsibilities in these areas?

☐ yes (Proceed to Question 25)

☐ no (Skip to Question 29)

25. In the table below, please indicate whether or not your unit has the authority to take the actions listed and, if so, if it has exercised this authority in FY-1976.

ADMINISTRATIVE ACTION	Has authority		Action taken FY76		Don't know
	Yes	No	Yes	No	
1. Suspend providers	22	9	15	11	6
2. Terminate providers	23	11	17	12	5
3. Recoup money	33	2	23	8	5
4. Issue warning letters	32	3	25	5	5
5. Flag for continued surveillance of provider	33	2	31	1	5
6. Suspend or deny payment, pending further review	27	8	24	5	5
7. Impose administrative fines or penalties	4	28	3	15	7
8. Other (Specify) _____					
_____					
_____					
_____					

26. If you have suspended or terminated a provider, please complete the table below indicating the number of providers in each category who were suspended, terminated or re-entered the program (after suspension) during FY 1976.

Type of Provider	Number Terminated	Number Suspended	Number Reentered
Practitioners	*	**	**
Hospitals	**	**	**
Nursing Homes	**	**	**
Pharmacies	**	**	**
Laboratories	**	**	**
Other (Specify)			

*Cannot be meaningfully averaged because of an extremely high report from Ohio. See data tabulation sheets for individual state responses.

**See data tabulation sheets for individual state responses.

27. Based upon the total number of cases in which you attempted to recover funds in FY76, in what percentage of the cases did you face the following obstacles to recovery?

Obstacle	0%	1-5%	6-10%	11-25%	26-50%	51-100%
Bankruptcy declaration	18	4	0	0	0	0
Flight from the state by the provider	18	6	0	1	0	0
Dissolution of corporation or legal entity	15	7	0	1	0	0
Simple non-payment	14	8	1	1	1	1

28. Please complete the table below indicating the amount of restitution identified and the amount actually recovered for each provider category during FY 1976.

Provider	Amount Identified	Amount Recovered	Don't Know
Practioners	$ *	$ *	5
Hospitals	$ *	$ *	7
Nursing Homes	$ *	$ *	5
Laboratories	$ *	$ *	5
Pharmacies	$ *	$ *	4
Other (specify)_____	$_____	$_____	
_____	$_____	$_____	
_____	$_____	$_____	
Total	$ *	$ *	

*These data cannot be meaningfully averaged. See data tabulation sheet for individual state responses.

NEEDS AND PLANS

29. This section is designed to obtain information on the agencies with which your unit coordinates, the resources your unit needs to control fraud and abuse, and any planned changes by your unit which would strengthen fraud and abuse control activities. If you have completed any portion of this questionnaire, please answer the questions in this section.

30. The table below contains a list of agencies with which many state abuse and fraud surveillance and investigation units choose to coordinate. It also lists other specific units mentioned in a preliminary survey as having fraud and abuse responsibilities. Please indicate (1) the extent of contact between your unit and each agency or unit, and (2) the extent to which these contacts have been productive.

AGENCY	EXTENT OF CONTACT			PRODUCTIVITY OF CONTACTS			
	None	Sporadic	Regular	Excellent	Satisfactory	Needs Improvement	Unsatisfactory
U.S. Attorney's Office	11	21	3	3	12	8	2
State Investigative Units	6	10	20	9	16	4	3
Attorney General's Office	2	14	19	10	15	5	4
County (or other local) Police	15	14	4	2	11	4	6
County (or other local) Prosecutor	9	18	6	2	9	10	1
State Health Department	1	15	19	11	15	5	1
Welfare Assistance Payments or Social Services Office	0	14	23	12	18	3	2
Comptroller or State Budget Office	20	6	8	5	7	1	0
Claims Processing Management and Design Staff	4	8	22	12	11	7	0
Utilization Review Committees	9	11	16	6	11	7	0
P.S.R.O.'s or Advisory Groups	8	11	18	6	14	4	1
Licensing Authorities	5	12	21	11	15	3	0
Office of Consumer Affairs	24	8	1	2	4	2	1
Office of Public Information	24	8	1	1	6	3	1
Fiscal Intermediaries	4	7	23	14	6	8	1
Provider or Public Interest Organization	7	17	9	6	14	4	0
HEW Regional Office	1	14	23	9	16	9	1
Bureau of Health Insurance (Medicare)	7	21	7	7	12	8	1
Other _____							
_____							
_____							

31. We are interested in learning about any changes you anticipate implementing in the next 12 months to improve your unit's ability to prevent, detect, investigate, and seek action against fraudulent or abusive providers. The tables below list a number of possible changes you may be considering. Please add to this list any other changes you are planning in each of the categories listed. Then, please check all boxes that describe the current status of each planned change.

Area of Change	Specific Type of Change	No Change Planned	Current Status of Possible Changes						
			Plans for Change						
			Not Yet Developed	Lack Administrative Approval	Lack Legislative Authority	Not Yet Funded	Not Yet Implemented	In Process of Implementation	Approved Implementation Date
Administrative Procedures	-unit or departmental reorganization	9	1	2	0	5	2	10	0
	- creation of "fraud unit"	19	3	3	0	3	0	7	0
	- establishment of new special committees or task forces	26	3	0	0	2	1	3	0
Prevention Methods	- change or modify certification procedures	19	2	0	0	1	1	7	0
	- change or modify reimbursement rate setting procedures for institutions	15	0	1	1	0	3	7	0
	- changes in claims processing system to detect improper bills prior to payment	11	8	1	0	0	2	7	0
	- administrative authority to withhold payment pending review	21	3	0	1	0	0	2	0
	- provider education/public relations programs	13	5	2	0	2	2	8	0
Detection Methods	- installation of hot line	27	2	1	0	0	0	1	0
	- more frequent audits	11	5	1	1	4	1	8	0
	- change in auditing methods	12	8	1	0	1	2	6	0
	- implementation of verification of services	16	3	0	0	0	2	8	0
	- implementation of MMIS	8	9	0	1	4	5	8	0
	- changes in data supplied in routine computer reports	6	12	0	1	2	2	8	0
	- changes in data supplied in exception reports	8	10	0	1	0	5	7	0
	- additional claims processing staff	18	3	1	2	2	1	2	1
	- additional auditing staff	12	3	2	2	3	0	7	1
	- special training program for auditors	15	8	0	0	0	1	6	0
	- special training program in review of computer reports	15	7	1	0	1	0	6	0

Area of Change	Specific Type of Change	No Change Planned	Current Status of Possible Changes						
			Plans for Change						
			Not Yet Developed	Lack Administrative Approval	Lack Legislative Authority	Not Yet Funded	Not Yet Implemented	In Process of Implementation	Approved Implementation Date
Investigation Techniques	- additional investigative staff	8	7	3	2	6	4	10	0
	- special training program for investigators	13	6	1	0	0	5	10	1
	- establish peace officer status for investigators	18	3	0	1	0	0	2	0
	- establish new criteria for assigning cases for investigation	20	9	0	0	0	1	6	0
	- improve liaison with criminal justice officials	18	7	0	0	0	2	7	0
	- obtain subpoena power	28	3	0	1	0	0	4	0
Administrative Actions	- modify hearings procedures	21	5	0	0	0	1	3	0
	- obtain authority to suspend providers	22	4	0	0	0	0	3	0
	- obtain authority to terminate providers	24	3	0	0	0	0	2	0
	- change procedures for negotiating settlements	24	2	0	0	0	0	4	0
	- change criteria for referral to law enforcement officials	20	7	0	0	0	0	2	0
Other (specify)									

32. We are interested in understanding what resources (including personnel, funding, technical assistance, etc.), authority, and state and Federal regulatory or legislative changes you feel would significantly improve your unit's ability to take comprehensive action to control Medicaid provider fraud and abuse. Please indicate briefly under each category listed below the kinds of changes you feel would enable your unit to be more effective in controlling fraud and abuse.

Fraud and Abuse Control Activity Affected	Type of Change Desired			
	Resources	Authority	State Regulations or Legislation	Federal Regulations or Legislation
Prevention	*	*	*	*
Detection	*	*	*	*

*See state response files.

32. Continued

Fraud and Abuse Control Activity Affected	Type of Change Desired			
	Resources	Authority	State Regulations or Legislation	Federal Regulations or Legislation
Investigation	*	*	*	*
Administrative Actions	*	*	*	*
Criminal Justice System Policy and Actions	*	*	*	*

*See state response files.

MEDICAID RECIPIENTS

SECTION II

1. The questions in this section are designed to obtain information on the detection and investigation of fraud or abuse by Medicaid recipients other than fraud specifically involved in initially obtaining or maintaining eligibility for Medicaid benefits. Also included are questions concerning actions taken against those abusing or defrauding the program in ways unrelated to eligibility. Do you have responsibility for controlling Medicaid recipient fraud?

☐ yes (Proceed to Question 2)

☐ no (Skip to Section III, page 39)

2. The table below lists several types of fraud and abuse recipients have reportedly used to obtain improper benefits from the Medicaid program. Based upon the total number of cases of recipient fraud/abuse in FY76, please complete the table below indicating (1) the percentage of each type of fraud or abuse occurring in your state, and (2) whether, when it does occur, it typically involves a relatively small or large number of dollars in improper payments per case.

Type of fraud or abuse	Don't know	Frequency				Dollars Involved	
		0-25%	26-50%	51-75%	76-100%	Small amount	Large amount
Selling Medicaid cards	24	11	0	0	0	5	0
Lending Medicaid cards	11	22	3	0	0	17	2
Unnecessary utilization of services	8	21	3	3	0	9	10
Failure to report third party reimbursement	7	21	4	2	0	8	11
"Doctor shopping" 1/	8	18	5	2	2	12	7
"Pharmacy shopping" 2/	9	19	4	1	2	15	4
Forged prescriptions	13	22	0	0	0	14	1
Other (specify)_____							
_____							
_____							

1/ Refers to the practice of visiting several doctors for the purpose of obtaining (1) larger amounts of a prescribed drug than is normally prescribed by a single physician or (2) several interactive drugs not customarily prescribed by the same physician.

2/ Refers to the practice of visiting several pharmacies to have multiple prescriptions for the same or interacting drugs filled simultaneously.

3. In the table below please indicate the frequency with which the following detection methods produced cases of suspected Medicaid recipient fraud or abuse not related to eligibility:

Detection Method	Frequency		
	Never or rarely	Occasionally	Frequently
Review of patient profiles	2	15	14
Referral from welfare agency	6	20	8
Third party complaints	5	24	4
Law enforcement officials	24	8	1
Other (specify) _____			
_____			
_____			

The following questions relate to the procedures for issuing a Medicaid identification card and the format of such a card, since such methods may serve to prevent or detect recipient fraud and abuse.

4. Does a photograph of the recipient appear on the identification card?

- 0 Yes
- 35 No

5. For what time period is the Medicaid card valid?

- 29 one to two months
- 3 three to five months
- 2 six to eight months
- 0 nine to eleven months
- 2 twelve months or more

6. How are Medicaid cards obtained by a recipient? (Check as many as applicable.)

- [23] mailed with a public assistance check
- [15] mailed separately from public assistance check
- [4] picked-up in person
- [1] other (specify) _____

_____

7. How frequently is a recipient informed of the penalties for a fraudulent use of the Medicaid card?

- [13] at the time of application only
- [11] each time they receive a new Medicaid card
- [ ] _____ times per year

8. Do you use a computer in your recipient fraud and abuse detection activities?

- [26] Yes
- [7] No (Skip to No. 12)

9. Please indicate in the table below the types of reports that are routinely generated for your recipient abuse and fraud detection/investigation activities, how often they are generated, and attach sample copies to this questionnaire.

Report Type	How Often Generated	Copy Attached	Copy Not Attached (Explain)
*		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
*This data cannot be meaningfully averaged. See state response files.		☐	☐ _____

10. What other reports, not generated routinely, are available upon request by your unit and how long does it take to obtain each type of report desired? Please attach sample copies.

Report Type	Turn Around Time	Copy Attached	Copy Not Attached (Explain)
*		☐	☐ _____ _____
		☐	☐ _____ _____
		☐	☐ _____ _____
		☐	☐ _____ _____
		☐	☐ _____ _____
		☐	☐ _____ _____

*This data cannot be meaningfully averaged. See state response files.

11. Does your computer system maintain a record of other third party health benefits (i.e. insurance, Medicare, etc.) to which a recipient is entitled?

☐ 19 Yes

☐ 5 No

12. In the table below, please indicate (1) whether or not your unit has the authority to perform the following functions with respect to Medicaid recipients and (2) whether the authority or lack of authority has had a positive effect, no effect, or a negative effect on your unit's ability to perform its investigative functions.

Function	Authority		Effect on Investigative Ability		
	Yes	No	Positive	No effect	Negative
Serve a search warrant	2	35	3	25	7
Serve a subpoena	11	26	8	21	6
Confiscate evidence	7	30	7	20	7
Review law enforcement records	17	20	15	14	6
Review financial records of providers	27	10	25	6	3
Review patient records	34	3	31	3	1
Make arrests	2	35	1	30	1
Have peace officer status	2	34	2	26	3
Other (specify) _____					
_____					
_____					

13. Please complete the form below, indicating the status of non-eligibility-related fraud and abuse investigations of Medicaid recipients by your unit in the fiscal years indicated.

	FY 75		FY 76	
Part I. Allegations and Results of In-house Documentation Review	Cases	Don't Know	Cases	Don't Know
A. Allegations awaiting in-house documentation review beginning of fiscal year	*	15	*	9
B. New allegations received or developed during fiscal year	*	11	*	5
C. Completed in-house documentation reviews	*	10	*	5
C.1 Allegations dropped	*	8	*	5
C.2 Cases referred for administrative actions	*	8	*	5
C.3 Allegations with evidence sufficient to merit field investigations	*	9	*	6
Part II. Field Investigations and Agency Enforcement Actions				
A. Field investigations in process at beginning of fiscal year	*	14	*	9
B. Field investigations begun during fiscal year	*	11	*	8
C. Cases referred to law enforcement officials	*	10	*	8
D. Field investigations closed by administrative action	*	10	*	8
E. Field investigations dropped for lack of evidence	*	10	*	8
Part III. Law Enforcement Actions and Prosecutions				
A. Cases awaiting law enforcement actions or in prosecution at beginning of fiscal year	*	13	*	10
B. Law enforcement actions completed and cases closed	*	11	*	9
Part IV. Amounts Recovered During Fiscal Year	Dollars			
A. Amount identified as improperly obtained	*	12	*	10
B. Amounts recovered from prosecution	*	12	*	9
C. Total amount recovered from all sources, including prosecutions	*	11	*	8

*This data cannot be meaningfully averaged. See data tabulation sheets for individual state responses.

14. In the table below, please indicate whether or not your unit has the authority to take the actions listed and, if so, if it has exercised this authority in FY 1976.

Action	Has authority		Action Taken FY76		Don't know
	Yes	No	Yes	No	
Remove recipient from the rolls	6	28	4	4	1
Recoup money	18	16	9	4	6
Suspend or deny use of the Medicaid card pending further review	7	26	1	4	1
Impose administrative fines or penalties	1	29	0	4	2
Require recipient to obtain services from a specified doctor, pharmacy or other provider	17	17	10	6	1
Other (Specify)					

15. We are interested in learning about any changes you anticipate implementeng in the next 12 months to improve your unit's ability to prevent, detect, investigate, and seek action against fraudulent or abusive providers. The tables below list a number of possible changes you may be considering. Please add to this list any other changes you are planning in each of the categories listed. Then, please check all boxes that describe the current status of each planned change.

Area of Change	Specific Type of Change	No Change Planned	Current Status of Possible Changes						
			Plans for Change						
			Not Yet Developed	Lack Administrative Approval	Lack Legislative Authority	Not Yet Funded	Not Yet Implemented	In Process of Implementation	Approved Implementation Date
Administrative Procedures	- unit or departmental reorganization	15	4	0	0	2	1	5	0
	- create "fraud unit"	16	4	2	0	2	1	3	0
	- establish new special committees or task forces	21	4	0	0	2	1	1	0
Prevention Methods	- change or modify Medicaid identification cards	15	2	0	0	0	0	3	0
	- change frequency of issuing Medicaid cards	19	0	0	0	0	0	1	0
	- modify recipient education/public relations programs	16	4	1	0	0	2	1	0
Detection Methods	- install hot line	20	3	0	0	0	0	1	0
	- institute more frequent audits	11	6	0	0	0	1	6	0
	- change auditing methods	16	2	0	0	0	0	3	0
	- implement verification of services	14	2	0	0	0	3	5	0
	- implement MMIS	7	6	0	0	2	4	5	0
	- change data supplied in routine computer reports	4	7	1	0	0	4	6	0
	- change data supplied in exception reports	9	6	1	0	0	3	4	0
	- hire additional claims processing staff	16	2	0	1	1	0	3	0
	- institute special training program in review of computer reports	11	6	0	0	0	3	6	0

Area of Change	Specific Type of Change	No Change Planned	Current Status of Possible Changes						
			Plans for Change						
			Not Yet Developed	Lack Administrative Approval	Lack Legislative Authority	Not Yet Funded	Not Yet Implemented	In Process of Implementation	Approved Implementation Date
Investigation Techniques	- hire additional investigative staff	11	1	2	1	5	2	7	0
	- institute special training program for investigators	11	5	1	0	0	3	9	0
	- establish peace officer status for investigators	23	1	0	2	0	1	0	0
	- establish new criteria for assigning cases for investigation	16	7	0	0	0	1	1	0
	- improve liaison with criminal justice officials	15	6	0	0	0	4	3	0
	- obtain subpoena power	21	1	0	3	0	1	1	0
Administrative Actions	- modify hearings procedures	19	4	0	0	0	1	2	0
	- obtain authority to suspend recipients	18	3	0	2	0	0	1	0
	- obtain authority to terminate recipients	16	4	0	2	0	0	1	0
	- obtain authority to designate place where recipient is to receive care	20	2	0	2	0	0	1	0
	- change procedures for negotiating settlements	21	3	0	0	0	0	2	0
	- change criteria for referral to law enforcement officials	20	3	0	1	0	1	2	0
Other (specify)									

16. We are interested in understanding what resources (including personnel, funding, technical assistance, etc.), authority, and state and Federal regulatory or legislative changes you feel would significantly improve your unit's ability to take comprehensive action to control Medicaid recipient fraud and abuse. Please indicate briefly under each category listed below the kinds of changes you feel would enable your unit to be more effective in controlling fraud and abuse.

Fraud and Abuse Control Activity Affected	Type of Change Desired			
	Resources	Authority	State Regulations or Legislation	Federal Regulations or Legislation
Prevention	*	*	*	*
Detection	*	*	*	*

*See state response files.

16. Continued

Fraud and Abuse Control Activity Affected	Type of Change Desired			
	Resources	Authority	State Regulations or Legislation	Federal Regulations or Legislation
Investigation	*	*	*	*
Administrative Actions	*	*	*	*
Criminal Justice System Policy and Actions	*	*	*	*

SECTION III

MEDICAID AGENCY

1. Questions in this section concern efforts that have been made by this department to combat potential fraud by agency personnel. More specifically, they focus on procedures you have instituted to detect fraudulent actions that have occurred, techniques you have employed to investigate cases of suspected agency fraud, actions you have taken against agency staff suspected of fraudulent activities, and procedures you have adopted to prevent employee fraud. Do you have responsibility for supervision and management of employees or an intermediary responsible for the operations of the Medicaid program or the investigation of employee fraud?

☐ yes (Proceed to Question 2)

☐ no (Thank you. Please return the survey to:

General Research Corporation
7655 Old Springhouse Road
McLean, Virginia 22101)

2. The table below provides a list of fradulent state or intermediary employee practices found in various Medicaid programs. Based upon the total number of agency fraud cases in FY76, please indicate (1) the percent of each kind of fraud in your state, and (2) whether, when it does occur, it typically involves a relatively large or small number of program dollars.

Type of Fraud	Fraudulent Action	Frequency				Dollar Amount	
		0-25%	26-50%	51-75%	76-100%	Small Amount	Large Amount
Accepting Kickbacks or Bribes	Improper use of computer overrides	6	1	0	0	1	0
	Improperly adjusting payment lag time	6	1	0	0	0	1
	Paying for improper claims or disallowable services	6	1	0	0	1	0
	Improper reporting by auditors/ investigators	6	0	0	0	1	0
Falsifying Records	Creating ficticious claims	6	1	0	0	0	1
	Doctoring provider profiles	7	0	0	0	0	1
	Altering computer files	7	0	0	0	1	0
Improper Use of Claims	Diversion of provider payments	7	0	0	0	1	0
Supression of Evidence	Failure to report/investigate	7	0	0	0	1	0
	Bribery to cover up	7	0	0	0	1	0
Other (specify)							

3. To what extent are criminal records checked for potential agency (intermediary) employees?

[5] Routinely for all applicants

[0] Routinely for a sample or subset of applicants

[6] Only if background check raises suspicions

[2] Never

[23] Don't know

4. To what extent are convicted felons excluded from employment?

[2] Excluded from all positions

[7] Excluded from particular positions

[1] Not excluded from any position

[26] Don't know

5. To what extent are employees given education/training explaining fraudulent actions and warning of the consequences for engaging in such actions?

[0] Substantial amount of training/education in this area

[5] Moderate amount of training/education in this area

[9] Limited amount of training/education in this area

[4] No training/education in this area

[19] Don't know

6. For which of the following actions are multiple signatures required? Please add other preventive measures requiring duplicate signatures as applicable.

Action	Multiple Signature Required		
	Yes	No	Don't Know
Authenticate a Claim	2	10	25
Approve a Claim Payment	2	10	25
Override an Edit Function	2	8	27
Change an Address File	2	10	25
Substantiate an Audit	6	4	27
Other (Specify) _____			
_____			
_____			

7. Based upon the total number of employee cases involving a question of fraud in FY76, please indicate the percentage of cases detected through each of the methods listed below.

Special Sample for Claims Control

Detection Method	Frequency			
	0-25%	26-50%	51-75%	76-100%
Recipient Verification of Services	7	1	0	0
Review and Edit of Claims	6	0	1	0
Review of Patient or Provider Profiles	7	0	0	0
Law Enforcement Referrals	6	0	0	0
Third Party Complaints	7	0	1	0
Supervisory Reviews	8	1	0	0
Special Audits or Investigations	8	0	0	0
Other (specify)				

8. Do you use a computer as a tool in your employee fraud detection or investigation activities?

[4] Yes

[14] No (skip to Question 11)

9. Please indicate in the table below the type of reports that are routinely generated for your employee fraud detection/investigation activities, how often they are generated, and attach sample copies to this questionnaire.

Report Type	How Often Generated	Copy Attached	Copy Not Attached (Explain)
*		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____

*This data cannot be meaningfully averaged. See state response files.

10. What other reports on agency fraud not generated routinely are available upon request by your unit and how long does it take to obtain each type of report desired? Please attach sample copies.

Report Type	Turn Around Time	Copy Attached	Copy Not Attached (Explain)
*		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____
		☐	☐ _____

*This data cannot be meaningfully averaged. See state response files.

11. Please complete the form below, indicating the status of Medicaid employee (and intermediary employee) fraud investigations by your unit in the fiscal years indicated.

	FY75		FY76	
Part I. Allegations and Results of In-House Documentation Review	Cases	Don't Know	Cases	Don't Know
A. Allegations awaiting in-house documentation review beginning of fiscal year	*	2	*	0
B. New allegations received or developed during the fiscal year	*	2	*	0
C. Completed in-house documentation reviews . .	*	2	*	0
C.1 Allegations dropped	*	2	*	0
C.2 Cases referred for administrative action	*	2	*	0
C.3 Allegations with evidence sufficient to merit field investigations	*	2	*	0
Part II. Field Investigations and Agency Enforcement Actions				
A. Field investigations in process at beginning of fiscal year	*	2	*	0
B. Field investigations begun during fiscal year	*	2	*	0
C. Cases referred to law enforcement officials .	*	2	*	0
D. Field investigations closed by administrative action	*	2	*	0
E. Field investigations dropped for lack of evidence	*	2	*	0
Part III. Law Enforcement Actions and Prosecutions				
A. Cases awaiting law enforcement actions or in prosecution at beginning of fiscal year . . .	*	2	*	0
B. Law enforcement actions completed and cases closed	*	2	*	0
Part IV. Amounts Recovered During Fiscal Year	$$$			
A. Amount identified as improperly obtained . .	*	2	*	0
B. Amounts recovered from prosecution	*	2	*	0
C. Total amount recovered from all sources, including prosecutions	*	2	*	0

*This data cannot be meaningfully averaged. See data tabulation sheets for individual state responses.

12. Which of the following administrative actions were taken against employees suspected of fraud during the indicated fiscal years.

Action	FY75			FY76		
	Yes	No	Don't Know	Yes	No	Don't Know
Transfer to Different Position	0	5	2	0	4	0
Suspend Employment	0	5	2	0	4	0
Terminate Employment	1	5	2	1	3	0
Refer for Prosecution	0	5	2	1	3	0
Recoup Money	1	4	2	0	4	0
Other (Specify)						

16. In the indicated fiscal years, how many employees have been:

Outcome	FY75		FY76	
	Number	Don't Know	Number	Don't Know
Suspended for Suspected Fraud	*	2	*	1
Dismissed for Suspected Fraud	*	2	*	1
Prosecuted for Suspected Fraud	*	2	*	1
Convicted of Fraud				

*This data cannot be meaningfully averaged. See data tabulation sheets for individual state responses.

14. We are intereated in learning about any changea you anticipate implementing in the next 12 montha to improve your unit's ability to prevent, detect, inveatigate, and seek action againat fraudulent employees or intermediary peraonnel. The tables below list a number of possible changes you may be considering. Please add to this list any other changea you are planning in each of the categoriea liated. Then, please check all boxea that describe the current status of each planned change.

Area of Change	Specific Type of Change	No Change Planned	Current Status of Poasible Changes						
			Plans for Change						
			Not Yet Developed	Lack Adminiatrative Approval	Lack Legislative Authority	Not Yet Funded	Not Yet Implemented	In Process of Implementation	Approved Implementation Date
Administrative Procedures	- unit or departmental reorganization	[14]	[2]	[0]	[1]	[1]	[0]	[1]	0
	- creation of "fraud unit"	[13]	[1]	[1]	[1]	[1]	[0]	[1]	0
	- establishment of new special committees or task forces	[15]	[1]	[0]	[0]	[0]	[0]	[2]	0
Prevention Methods	- alter employee education programs	[12]	[3]	[0]	[0]	[0]	[0]	[1]	0
	- change hiring and/or placement practices	[14]	[1]	[0]	[0]	[0]	[0]	[0]	0
	- modify signature requirements	[14]	[1]	[0]	[0]	[0]	[0]	[0]	0
	- alter rotation of casea among caseworkera	[14]	[1]	[0]	[0]	[0]	[0]	[0]	0
	- modify distribution of responsibilities among individuala or units	[13]	[2]	[0]	[0]	[0]	[0]	[1]	0
	- change physical location of unita	[15]	[1]	[0]	[0]	[0]	[0]	[0]	0
	- alter verification or redetermination procedures	[13]	[2]	[0]	[0]	[0]	[0]	[0]	0
	- modify payments procedures	[13]	[3]	[0]	[0]	[0]	[0]	[0]	0
	- change duplicate check procedures	[14]	[2]	[0]	[0]	[0]	[0]	[0]	0
	- alter access to computer files	[14]	[2]	[0]	[0]	[0]	[0]	[0]	0

Area of Change	Specific Type of Chsnge	No Change Planned	Current Status of Possible Changes						
			Plans for Change						
			Not Yet Developed	Lack Administrative Approval	Lack Legislative Authority	Not Yet Funded	Not Yet Implemented	In Process of Implementation	Approved Implementation Date
Detection Methods	- modify supervisory review frequency or procedures	13	1	0	0	0	0	0	0
	- change employee audit/investigation frequency or procedures	12	1	0	1	1	0	0	0
	- adjust computer system utilization	10	2	0	1	1	0	2	0
	- modify data included on computer-generated reports	11	3	0	0	0	0	1	0
	- alter use of quality control data (e.g. error prone profiles)	10	3	0	0	0	0	1	0
	- add supervisory staff	11	1	0	2	2	0	0	0
	- additional redetermination staff	12	1	0	2	1	0	0	0
	- special training program for verification or redetermination workers	12	2	0	1	1	0	0	0
Investigative Techniques	- additional investigative staff	11	1	1	1	2	0	1	0
	- special training program for investigators	11	2	0	1	1	0	2	0
	- establish peace officer status for investigators	15	1	0	0	0	0	0	0
	- establish new criteria for assigning cases for investigation	12	3	0	0	0	0	1	0
	- improve liaison with criminal justice officials	14	1	0	0	0	0	1	0
	- obtain subpoena power	14	1	0	0	0	0	1	0
Administrative Actions	- modify hearings procedures	14	1	0	0	0	0	0	0
	- obtain authority to remove recipient from the rolls	14	1	0	0	0	0	0	0
	- obtain authority to levy fines for misrepresentation	14	1	0	0	0	0	0	0
	- change procedures for negotiating settlements	14	1	0	0	0	0	0	0
	- change criteria for referral to law enforcement officials	13	1	0	0	0	0	0	0
Other (specify)									

Appendix A

RESPONDING STATES AND NOTES CONCERNING STATE RESPONSES

ALABAMA

The Alabama Medical Services Administration responded to all sections of the questionnaire. Section III does not provide any data as agency fraud has never been detected within the program.

ALASKA

No reply has been received from Alaska despite follow-up contact.

ARIZONA

Arizona does not have a Medicaid program.

ARKANSAS

The Arkansas questionnaire was partially completed by three units: the Fraud Detection Unit, the Utilization Unit and the Nursing Home Unit. Answers to Sections II and III were tallied from the Fraud Detection Unit. Portions of Section I were tallied from both the Detection and the Utilization Units. The Nursing Home Unit responses were not tabulated due to the limited nature of the responses.

CALIFORNIA

The California questionnaire was completed by two units. Section I was completed by the Drug Utilization Review Unit of the Department of Health, Medi-Cal Division. Sections I and II were also completed by the Investigations Unit. Neither unit indicated responsibility in Section III.

COLORADO

No reply was received from Colorado despite follow-up contact.

CONNECTICUT

The Connecticut questionnaire was partially completed by the Internal Audit section of the Department of Social Services. Section II was only partially completed and there was no response to Section III.

DELAWARE

The Medical Services Administration participated in the Delaware survey. They did not indicate responsibilities in fraud and abuse detection or investigation; therefore, large sections of the questionnaire were non-responsive.

DISTRICT OF COLUMBIA

The Medical Assistance Division of the Department of Human Resources responded to Sections I and II of the D.C. questionnaire. There was no response to Section III.

FLORIDA

The Utilization Review, HRS (PDSEM/UR) SES, Medical Services responded to the Florida questionnaire. Questions 17-23 were also answered by the Division of Public Assistance Fraud, Office of the Auditor General.

GEORGIA

The Georgia Department of Human Resources responded to a limited number of questions on the Georgia questionnaire.

HAWAII

No reply was received from Hawaii despite follow-up contact.

IDAHO

The Bureau of Medical Assistance responded to the questionnaire. Questions 17-23 were unanswered as the Bureau did not indicate responsibilities for investigating provider fraud and abuse.

ILLINOIS

No reply was received from Illinois despite follow-up contact.

INDIANA

No reply was received from Indiana despite follow-up contact.

IOWA

The Utilization Review Unit, Medical Services Section of the Iowa Department of Social Services, responded to Sections I and II of the questionnaire. Section III was not completed as the unit does not have responsibility in that area.

KANSAS

No reply was received from Kansas despite follow-up contact.

KENTUCKY

The Division for Medical Assistance of the Kentucky Department for Human Resources responded to all sections of the questionnaire.

LOUISIANA

No reply was received from Louisiana despite follow-up contact.

MAINE

The Department of Human Services responded to all sections of the Maine questionnaire, although they indicated that information was not available as a response to several questions.

MARYLAND

No reply was received from Maryland despite follow-up contact.

MASSACHUSETTS

The Bureau of Welfare Auditing partially responded to the Massachusetts questionnaire.

MICHIGAN

The Office of the Inspector General responded to Sections I and II of the Michigan questionnaire. Section III was not completed.

MINNESOTA

No reply was received from Minnesota despite follow-up contact.

MISSISSIPPI

The Medicaid Commission-Utilization Review responded to the Mississippi questionnaire. They did not indicate responsibility for Section III.

MISSOURI

Both the Medical Services Section and the Division of Investigation responded to the Missouri questionnaire. All answers were tallied from the Medical Services Section's responses.

MONTANA

The Program Integrity Bureau responded to the Montana questionnaire. They did not report responsibility for investigation, thus questions 17-23 were unanswered.

NEBRASKA

The Department of Public Welfare responded to all sections of the Nebraska questionnaire. Input was received from the Division of Medical Services, the Division of Program Evaluation and Review, and the Division of Management and Data Services.

NEVADA

The Medicaid Compliance Monitoring Section of the Welfare Division responded to all sections of the Nevada questionnaire.

NEW HAMPSHIRE

Responses were received from the Office of Medical Services, Bureau of Quality Assurance, Fair Hearings Division of Welfare, and the Bureau of Operations. Questions 17-23 were tabulated from the Bureau of Quality Assurance. The remainder of Section I and all of Section II were tabulated from the Office of Medical Services. No unit indicated responsibility for Section III.

NEW JERSEY

The Division of Medical Assistance and Health Services, Program Integrity Administration, responded to Sections I and II. No responsibility was indicated for Section III.

NEW MEXICO

The Medical Assistance Division, the Special Investigations Section of the Office of General Council, the Office of Field Operations, State Welfare Agency, and the Financial Assistance Division, SWA, all responded to various sections of the New Mexico questionnaire.

NEW YORK

No reply was received from New York despite follow-up contact.

NORTH CAROLINA

Replies to the North Carolina questionnaire were received from the Medical Services Section of the Department of Human Resources, the Medical Peer Review Foundation and the EDSF Corporation. Sections I and II were completed but there was no reply to Section III.

NORTH DAKOTA

The North Dakota questionnaire was completed by the Medical Services Unit.

OHIO

Sections I and II of the Ohio questionnaire were completed by the Bureau of Surveillance and Utilization Review, Division of Medical Assistance. Section III was not completed.

OKLAHOMA

The Oklahoma questionnaire received responses from both the Special Medical Services Unit and the Medicaid Prescription Drug Program. Both organizations responded to Section I; however, the Medicaid Prescription Drug Program's responses were tabulated only for pharmaceutical questions. Only the Special Medical Services Unit responded to Section II and neither organization responded to Section III.

OREGON

The Medical Utilization-Medical Assistance Unit of the Health and Social Services Section responded to the questionnaire. They did not report responsibility and did not answer any questions in Section III.

PENNSYLVANIA

The Office of Family Assistance, Department of Public Welfare, responded to Sections I and II of the Pennsylvania questionnaire. They were not responsible for employee fraud and did not complete Section III.

RHODE ISLAND

Both the Medical Standards and Review and the Investigation and Prosecution Units responded to all three sections of the questionnaire.

SOUTH CAROLINA

The Office of Investigation, DSS, responded to the South Carolina questionnaire. Questions 7-9, 11-13, 15, 16, 25-29 and all of Section III were unanswered.

SOUTH DAKOTA

No reply was received from South Dakota despite follow-up contact.

TENNESSEE

The Fraud and Abuse Section, Medicaid Division, responded to the Tennessee questionnaire. They did not indicate responsibility and did not complete Section III.

TEXAS

The Utilization Control, Utilization Review, Audit Division and Investigation Division of the Office of the Deputy Commissioner for Medical Programs and the National Health Insurance Company all responded to various sections of the Texas questionnaire.

UTAH

The Office of Recovery Services responded to Sections I and II of the Utah questionnaire. Thet did not report responsibility for Section III.

VERMONT

The Medical Assistance Division, Department of Social Welfare, responded to all sections of the Vermont questionnaire.

VIRGINIA

The Bureau of Medical Assistance, Virginia State Health Department, responded to all sections of the questionnaire.

WASHINGTON

The Medical Services Review Unit and the Office of Special Invesitgations responded to the Washington questionnaire.

WEST VIRGINIA

The West Virginia Department of Welfare, Management Information Systems, Division of Medical Care, Office of Administrative Review, and the Division of Communications all responded to various sections of the questionnaire.

WISCONSIN

The Department of Health and Social Services responded to the Wisconsin questionnaire. Insufficient data precluded their answering many questions. Most of Section II and all of Section III were not completed.

WYOMING

The Medical Assistance Service responded to the Wyoming questionnaire.

Appendix B

SURVEY PACKET MAILED TO POTENTIAL RESPONDENTS*

*The survey instrument reproduced in Section II is not again reproduced here although it was included in the packet.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

INFORMATION REQUESTED

ACTION TRANSMITTAL
SRS-AT-77-18 (OPRE)
February 3, 1977

TO: STATE AGENCIES ADMINISTERING AFDC AND/OR MEDICAID

SUBJECT: Questionnaire concerning State activities in Medicaid or AFDC Related Fraud and Abuse Control

STATUTORY REFERENCE: Section 1110 of the Social Security Act

PROGRAM APPLICABILITY: Financial and medical assistance programs

BACKGROUND: The Congressional Committee on Governmental Operations, in January 1976, asked SRS to compile information on States' activities in regard to preventing, prosecuting, and otherwise controlling fraud and abuse in the AFDC and Medicaid programs. Accordingly, the General Research Corporation has been hired to coordinate a study on State fraud and abuse efforts. The attached questionnaire, approved by the Office of Management and Budget, will provide important background and the basis for further dialogue and mutual assistance between SRS, States, and the Congress in improving efforts in achieving program integrity.

ACTION REQUESTED: Comply with instructions attached, which specify procedures for filling out questionnaires or nominating appropriate respondents. Return within specified time period to:

General Research Corporation
7655 Old Springhouse Road
Westgate Research Park
McLean, Virginia 22101
ATTN: Robert Oshel

INQUIRIES TO:

David Arnaudo, Director
Income Maintenance Evaluation Group
Office of Planning, Research and Evaluation
Social and Rehabilitation Service
330 C Street, S.W., Room 5528
Washington, D.C. 20201
Phone: 202-245-0703

or

Dr. Robert Oshel
General Research Corporation
7655 Old Springhouse Road
Westgate Research Park
McLean, Virginia 22101
Phone: 703-893-5900, Ext. 436

Associate Administrator
Office of Planning, Research, and Evaluation

GENERAL RESEARCH CORPORATION

7655 OLD SPRINGHOUSE ROAD
MCLEAN, VIRGINIA 22101
TELEPHONE 893-5900 (AREA CODE 703)

Letter to State with Identified Respondents

[illegible] 1977

Dr. Henry Foley
Executive Director
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203

Dear Dr. Foley:

This survey has been designed to achieve two objectives:

— To collect the minimum data required to provide DHEW with a national data base of state fraud and abuse control activities, and

— To provide the states with a survey document and procedure which imposes a minimum burden for completion.

Working with the DHEW regional office, GRC has attempted to identify those organizational units within Colorado which appear to conduct activities about which information is required for this survey. The survey questionnaire is divided into subsections by functional area so that each organizational unit can easily identify the sections of the questionnaire to which it needs to respond. In accordance with the survey design, questionnaires and instructions will be mailed to each of the units identified on the attached mailing list approximately two weeks from the date of this letter. Although we believe this procedure is best for most states, we are providing this information to you in advance of the general mailing so that you may advise us if alternate arrangements are more satisfactory and so that you can effectively coordinate the response on behalf of your program. We are requesting that completed questionnaires be returned to General Research Corporation within four weeks of the general mailing which will follow this letter.

I would be more than happy to answer any questions or discuss the survey with you. Please feel free to contact me or Ms. Susan Schechter at (703)893-5900.

Thank you in advance for your cooperation.

Sincerely,

Robert E. Oshel

Robert E. Oshel, Ph.D.,
Project Director

An Equal Opportunity Employer M/F

GENERAL RESEARCH CORPORATION

7655 OLD SPRINGHOUSE ROAD
WESTGATE RESEARCH PARK
McLEAN, VIRGINIA 22101
(703) 893-5900

Letter to State without Identified Respondents

Jerome A. Lackner, M.D., Director
Department of Health
714 P Street
Sacramento, California 95814

Dear Dr. Lackner:

As discussed in the covering memorandum from DHEW/SRS, the enclosed mail survey questionnaires which will be used to develop a national data base on fraud and abuse control activities in all fifty states represent the second major element of General Research Corporation's project to assist SRS in this critical area. The national data base will be complementary to the "Best Practices" case studies and Federal Options analysis for which selected states have been visited. We greatly appreciate the assistance which the Department has already provided us. Now it is equally important that these mail survey questionnaires be completed so that California is represented in the national data base with data comparable to that being provided by the other states.

To assist states in completing the questionnaires, they have been organized into sections which correspond to functional areas of program administration. Therefore, the questionnaires can be distributed to various individuals for completion of various sections, if appropriate, and thereby minimize the burden on any one individual. Please note that the Survey of Unit Budget and Staffing Characteristics form is to be completed for each organizational unit whose functions are addressed by any portion of the Medicaid questionnaires.

To allow adequate time for processing the data, we are requesting that the completed survey forms be returned to General Research Corporation within the next four weeks.

If you or your staff have any questions about the survey or use of the questionnaires, please call me or Ms. Susan Schechter at (703) 893-5900.

Thank you for your assistance.

Sincerely,

Robert E. Oshel

Robert E. Oshel, Ph.D.
Project Director

AN EQUAL OPPORTUNITY EMPLOYER M/F

INSTRUCTIONS

FRAUD AND ABUSE CONTROL SURVEY

The Fraud and Abuse Study involves three survey questionnaires:

- Medicaid Fraud and Abuse Control Survey
- AFDC Fraud Control Survey
- Survey of Unit Budget and Staffing Characteristics

Each respondent has been mailed a Medicaid and/or AFDC questionnaire as appeared appropriate to his/her area of responsibility and a Unit Budget and Staffing Characteristics Questionnaire. Each questionnaire is designed to be self-explanatory. These instructions are provided as general guidance on the overall structure of the questionnaires.

Medicaid and AFDC questionnaires

To assist the respondent, these questionnaires are subdivided as follows:

Medicaid Fraud and Abuse Control Survey

Section I - Medicaid Provider	
Detection Methods	Page 1, Question #1
Investigative Methods	Page 9, Question 17
Administrative Action	Page 17, Question 24
Needs and Plans	Page 21, Question 29
Section II - Medicaid Recipients	Page 27, Question 1
Section III - Medicaid Agency	Page 39, Question 1

AFDC Fraud Control Survey

Section I - AFDC Recipient Fraud	
Verification of Eligibility	Page 1, Question 1
Redetermination of Eligibility	Page 11, Question 11
Payment	Page 21, Question 30
Investigation	Page 27, Question 45
Administrative Actions, Restitution Referral for Prosecution	Page 31, Question 50
Needs and Plans	Page 31, Question 61
Section II - AFDC Agency Fraud	Page 43

Each subsection contains an introduction which explains the types of questions in the section so that you may review whether the subsection is relevant to your activities. If the subsection is relevant, check the "yes" box and answer the questions in that subsection. If the answer is no, check the "no" box and proceed to the next subsection. Please respond to every question within a subsection. That is, some of the questions in a subsection may relate to your activities, but not all. In those that you cannot provide information, please fill in "not applicable"; "not our unit's responsibility," or some other indication that the question was considered and not accidentally skipped. The "needs and plans" subsections should be completed if information was provided in any of the subsections prior to "needs and plans."

Please feel free to provide any additional comments or information which you feel will provide us with a better understanding of your unit's activities.

In cases where more than one individual or organizational unit is completing sections of the AFDC and/or Medicaid questionnaire, the state may either return fully completed questionnaires or several questionnaires with various sections filled out representing one complete response for the program involved. Survey of Unit Budget and Staffing Characteristics forms should be completed for each unit about which information is provided in the AFDC and/or Medicaid questionnaire.

Please return completed questionnaires to General Research Corporation in the enclosed self-addressed envelope. If at any time there are questions or problems in completing the questionnaire, please contact Dr. Robert Oshel or Ms. Susan Schechter at General Research Corporation, 703-893-5900. Questionnaires are to be returned within four weeks and, if there are any problems in returning them in that time frame, we would appreciate notification to that effect.

For your convenience, our records show that we will anticipate receipt of your completed questionnaire by MAR 7 1977

GENERAL RESEARCH CORPORATION

OMB Number 83-S-75011
Expires: 5-77

SURVEY OF UNIT BUDGET AND STAFFING CHARACTERISTICS

The questions in this section are part of a study of fraud and abuse control and are applicable to all units completing the Medicaid and/or AFDC surveys. They are designed to obtain information about your unit's budget and allocation of staff time. For purposes of this study, a "unit" is defined as the smallest entity of that Department of which the respondent is a member and which has its own operational budget. These questions are being asked in order to understand the costs as well as benefits of the fraud and abuse control activities in your state.

State: _____

Organization Unit

Name: _____

Address: _____

_____

_____

Respondent

Name: _____

Position: _____

Telephone: ( ) - _____

Please return this questionnaire by: MAR 7 1977

to: General Research Corporation
7655 Old Springhouse Road
McLean, Virginia 22101

1. What were the total expenditures of this unit in Fiscal Year 1976?

$_____

2. How many people (or full-time equivalent staff) does this budget cover?

Type of Staff Member	Person Equivalents
Professional	
Support/Clerical	

3. Approximately what proportion of this unit's fraud and abuse control activities are concerned with the following types of fraud and abuse?

Type of Fraud (and Abuse)	Percent
Medicaid Provider Fraud/Abuse	%
Medicaid Recipient Fraud/Abuse	%
Medicaid Agency (or Intermediary) Fraud/Abuse	%
AFDC Recipient Fraud	%
AFDC Agency Fraud	%
Child Support Enforcement	%
Other Assistance Programs (Specify) _____	%
	%
Total	100 %

4. Professional staffs of agencies that administer AFDC and Medicaid programs typically perform a wide range of functions including such fraud or abuse control related functions as those listed in the table below. For each of the listed functions that <u>is</u> performed by this unit, please indicate: (1) the extent to which performance of this function is related to fraud or abuse control activities and (2) the percentage of the total <u>professional</u> staff time of this unit that is devoted to performance of this function.

Function	Percent of Professional Staff Time Devoted to This Function	Relation of Function to Fraud Control			
		Not at all Related	Related a Little	Moderately Related	Completely Related
Initial Eligibility Verification	%	☐	☐	☐	☐
Eligibility Redetermination	%	☐	☐	☐	☐
Claims Review and Verification	%	☐	☐	☐	☐
Payment	%	☐	☐	☐	☐
Surveillance and Utilization Review	%	☐	☐	☐	☐
Other Fraud/Abuse Prevention	%	☐	☐	☐	☐
Other Fraud/Abuse Detection	%	☐	☐	☐	☐
Case Screening/Referral for Investigation	%	☐	☐	☐	☐
Fraud/Abuse Investigation	%	☐	☐	☐	☐
Administrative Case Disposition	%	☐	☐	☐	☐
Interaction with Law Enforcement Agencies	%	☐	☐	☐	☐
Program Administration	%	☐	☐	☐	☐
Other (Specify) _____	%	☐	☐	☐	☐
Total	100 %				

ATTACHMENTS

5. Please attach copies of the following documents. If you do not use such a document or a copy is not available please explain why.

a. If a study has been made in the last three years of how your organization's staff time is allocated, please attach a copy.

☐ No such study done

☐ Copy attached

☐ Copy not available (explain) _____

_____

_____

b. State or other organization chart(s) showing the relationship between your unit and all other state, county, local, or private agencies (fiscal intermediaries, medical societies, etc.) which play a role in abuse and fraud control.

☐ No such chart(s) exist

☐ Copy attached

☐ Copy not attached (explain) _____

_____

_____

c. A copy of the budget for your unit and the budget for the division or agency your unit is responsible to.

☐ No such budget(s) exist

☐ Copy attached

☐ Copy not attached (explain) _____

_____

_____

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